Alberta Health Services

Affix patient label within this box

Developmental Pediatric Referral

Referral Criteria for Pediatric Rehabilitation

- Child must be under 18 years of age
- Child must display 2 or more complex developmental/behavioral concerns that require multidisciplinary approach and specialist medical consultation
- Child has accessed appropriate Primary & Secondary services *(e.g. community services, school based)* prior to referral
- Psycho-educational assessment has been completed *(when concern is related to learning and associated functioning in a school age child)*

Please return completed form to: **Glenrose Rehabilitation Hospital, Pediatric Rehabilitation Central Intake**

Mail: Room 0603, 10230 111 Ave Edmonton AB, T5G 0B7
Email: GRHpedscentralintake@ahs.ca
Fax: 780.735.6293

Patient Name *(first, middle, last)*		Name at Birth *(if different)*	
Gender ☐ Male ☐ Female	Date of Birth *(yyyy-Mon-dd)*	Personal Health Number	Home Phone
Address	City	Province	Postal Code
Parent/Legal Guardian Name *(print)*		Parent/Legal Guardian Name *(print)*	
Relationship to Child	Phone Number	Relationship to Child	Phone Number
Email address		Is Interpreter required? ☐ No ☐ Yes *(Specify Language)* _____	
Is the child under the care of Child and Family Services? ☐ No ☐ Yes →		Case Worker *(name)*	Phone Number

Who initiated this referral? (please attach detailed concerns documented by parents, if available)

☐ Physician/Nurse Practitioner
☐ Family
☐ Daycare/Preschool/School *(specify)* _____
☐ Community Service/Resource *(specify)* _____
☐ Other *(specify)* _____

Which community based services have been accessed? *(Check all that apply. If possible, please provide documents with referral)*

(✓)	Services	Date *(yyyy-Mon-dd)*	Location
	Speech & Language		
	Audiology		
	Occupational Therapy, Physiotherapy		
	Mental Health		
	Psycho-educational		
	Other *(e.g. school/program)*		

☐ **I have reviewed and discussed the details of this referral with the child's family**	Initials

Alberta Health Services collects information about you in accordance with Section 20 of the Health Information Act (HIA) for the purpose of providing you health services, determining your eligibility for health services, or to carry out any other purpose authorized by the HIA. Your information will be collected directly from you, except in the limited circumstances where we are authorized by the HIA to indirectly collect such information. If you have any questions about this collection, please ask your care provider or contact Pediatrics Central Intake

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Medical teams at Glenrose Rehabilitation Hospital work in a consultant model with community providers and do not “take over” care. The primary care Physician or Nurse Practitioner must be involved to assist the family with continued health maintenance, routine developmental surveillance and monitoring of ongoing and emerging medical concerns.

By submitting this referral, you are agreeing to participate in shared care for this patient.

Physician/Nurse Practitioner Referral Details	
Date of last physical exam *(yyyy-Mon-dd)*	Date of last vision exam *(yyyy-Mon-dd)*
List existing diagnoses *(attach relevant documents)*	
Describe your concerns for this patient in detail *(use additional pages as required)*	
Parent’s/Guardian’s concerns, as described to you *(use additional pages as required)*	

Referred By		**Family Physician** ***(if different)***	
Name		Name	
Phone	Fax	Phone	Fax
Address		Address	
City	Province	City	Province
Postal Code	Prac ID	Postal Code	Prac ID
Affix Stamp (must be legible and include name, address, Practice ID, office phone and fax)			
Physician/Nurse Practitioner Signature		Referral Date *(yyyy-Mon-dd)*	